2. IHS MNT Referral Form

IHS 199-1 (REV. 01/89)

PATIENT REFERRAL NOTICE

INSTRUCTIONS (This form may be used by Medical, Dental, and Paramedical personnel to refer DIH Beneficiaries for medical, dental or related services)

1. TO *(Name, title, and address of person or organization or institution to whom referral is made.)*

2. NAME OF PATIENT	3. SEX	4. BIRTH DATE	5. REGISTRATION

6. ADDRESS	7. TRIBE	8. RESERVATION

9. ADDITIONAL IDENTIFICATION

10. REASON FOR REFERRAL *(Type of service requested)*
RD to provide Medical Nutrition Therapy for _____(hours) for _____(note reason)
(e.g., controlled, uncontrolled, change in medical management)

☐ Type 1 Diabetes, controlled ☐ Type 2 Diabetes, controlled ☐ Gestational Diabetes, controlled
☐ Type 1 Diabetes, uncontrolled ☐ Type 2 Diabetes, uncontrolled ☐ Gestational Diabetes, uncontrolled

Complicating conditions: ☐ HTN ☐ Dyslipidemia ☐ Nephropathy due to _____ ☐ Neuropathy ☐ Other _____

11. SIGNIFICANT MEDICAL OR DENTAL FACTORS *(Including diagnosis, prognosis, treatments, etc.)*

YOUR GOALS FOR PATIENT:
☐ Improve A1c ☐ Improve Dyslipidemia ☐ Weight Management ☐ Improve BP ☐ Change in Medical Management*
☐ No previous MNT/nutrition education ☐ Other _____

EXERCISE RESTRICTIONS:
☐ **None → Initial and date** _____ *(Indicates medical clearance)*
☐ **Restrictions:** _____

CLINICAL DATA: ***(May attach current Health Summary)***

Ht _____ Wt _____ Blood Pressure _____ (include date)

A1c _____ LDL-C ____ HDL-C ____ TG _____ Microalb or Up/Ucr _____ Cr _____ Hgb _____ Ketones _____
Date(s) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )

MEDCATIONS: ***(May attach current Health Summary)*** _____

***MANAGEMENT TRAINING NEEDS:**
Insulin _____
Monitoring _____
Nutrition _____
Other _____

COMMENTS:

12. REPORT BY PARAMEDICAL PERSONNEL

13. FROM *(Name, title, and address of person making referral)* UPIN:	14. DATE